UNIVERSITY HEALTH SERVICES
Tang Center

University Health Services – UC Berkeley
2222 Bancroft Way, Berkeley, CA 94720
510.642.1804 – Fax: 510.642.1801

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION- Eating Disorder

Patient Information

Name (Last, First, Middle) _____ _____

Address _____

Phone _____ Student ID _____ Date of Birth _____

Authorization

I authorize University Health Services (UHS) to mutually exchange information concerning my eating disorder treatment with the following people and/or organization:

Name _____ Phone: _____
Address _____ Fax: _____
_____
City _____ State _____ Zip Code _____
Relationship to patient, if applicable: _____

Name _____ Phone: _____
Address _____ Fax: _____
_____
City _____ State _____ Zip Code _____
Relationship to patient, if applicable: _____

Name _____ Phone: _____
Address _____ Fax: _____
_____
City _____ State _____ Zip Code _____
Relationship to patient, if applicable: _____

Name _____ Phone: _____
Address _____ Fax: _____
_____
City _____ State _____ Zip Code _____
Relationship to patient, if applicable: _____

Name _____ Phone: _____
Address _____ Fax: _____
_____
City _____ State _____ Zip Code _____
Relationship to patient, if applicable: _____

Expiration and Validity of Authorization

Unless otherwise revoked, this Authorization is effective immediately and shall remain in effect until _____. If no date is indicated, this Authorization will expire twelve (12) months after the date of requestor's signature at the bottom of this form.

_____ _____
Signature of the Patient or patient's legal representative Date

_____ _____
Printed name of signatory Witness (if patient is unable to sign) or Interpreter

_____
Relationship to patient (if signed by other than patient)

Notice

UHS and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time using the appropriate form available at the Health Records department or online at: https://uhs.berkeley.edu/medical/health-records.
The revocation form must be signed by you or your patient representative, and delivered to Health Records Department, University Health Services, 2222 Bancroft Way, Berkeley, CA 94720-4300. The revocation will take effect when UHS receives it, except to the extent UHS or others have already relied on it.

You are entitled to receive a copy of this Authorization upon request.